COLORADO
Department of Health Care Policy & Financing

Acentra HEALTH

Prior Authorization Request 2810 N. Parham Road Suite 305 Henrico, VA 23219	**ColoradoPAR Program** Medical Review Department	Phone: 1-720-689-6340 Fax: 1-800-922-3508

QUESTIONNAIRE #4
SEAT LIFT

Member Name		Health First Colorado ID #	

Length of Need		End Date		Height		Weight	

The information requested below is required to determine medical necessity. Complete this form and attach to the completed Prior Authorization Request (PAR).

1. What is the complete diagnosis with complicating factors?	
2. Is this request for an independent seat lift device or as a component of a power wheelchair? **Note**: If wheelchair component, complete DME Questionnaire #17.	□ Independent Seat □ Component of Power Wheelchair Lift Device
3. Is the seat lift mechanism intended to allow member to perform activities of daily living independently?	□ Yes □ No
4. Is the member completely incapable of standing from any chair in the home? If yes, is member able to ambulate independently with or without aides (cane, walker, etc.)?	□ Yes □ No □ Yes □ No
5. What past and current equipment has been utilized?	
6. Why isn't the current equipment (if any) meeting the member's needs?	
7. Supply any additional information that will assist us in determining **medical necessity** for this request:	

Print Prescriber Name _____

Prescriber Signature _____

Date _____